



## DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL SERVICES

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### SYNAGIS/RESPIGAM PRIOR AUTHORIZATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medicaid # \_\_\_\_\_ Request Date: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider #: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Submitted by/Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Synagis and Respigam are covered by the South Dakota Medicaid Program when a child meets one of the following criteria and **it has been recommended by a Neonatologist, Pediatric Pulmonologist, or Pediatric Cardiologist:**

- \_\_\_\_\_ A Children under 6 months of age at the onset of the RSV season who were 35 weeks and less gestational age at birth.
- \_\_\_\_\_ B Children under two years of age at the onset of the RSV season with evidence of ongoing lung disease such as bronchopulmonary dysplasia or cystic fibrosis requiring treatment with oral bronchodilators, supplemental oxygen, diuretics, or nebulized or inhaled medications to stabilize the disease in the last 6 months.
- \_\_\_\_\_ C Children under two years of age at the onset of the RSV season with immunodeficiencies that may make them more susceptible to severe lower respiratory tract disease related to RSV.
- \_\_\_\_\_ D Any child under two years of age at the onset of the RSV season felt to be at high risk for significant lower respiratory tract illness related to RSV.

DIAGNOSIS: \_\_\_\_\_

HOSPITALIZATIONS/TREATMENT/MEDICATIONS USED IN THE LAST 6 MONTHS:

\_\_\_\_\_  
\_\_\_\_\_

Medication: Synagis \_\_\_\_\_ Respigam \_\_\_\_\_ Gestational age at birth \_\_\_\_\_

Neonatologist, Pediatric Pulmonologist, or Pediatric Cardiologist: (REQUIRED)

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

*(Both physician signatures are required.)*

Prescribing physician: (REQUIRED)

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Location: Clinic \_\_\_\_\_ Home Health \_\_\_\_\_ Outpatient Hospital \_\_\_\_\_